

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92d)

CERTIFICATE OF DEATH

4917 203
★ Reg. Dist. No.

1. PLACE OF DEATH:

County..... Kent
City or town..... Rock Hall
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?..... Life
Hospital, institution, or street address where death occurred:.....
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State..... Maryland County..... Kent
City or town..... Rock Hall
(If outside city or town limits, write RURAL and give nearest town)
Street No.....
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME

George Ayres sen

3. (b) Social Security Number

4. Sex..... m. 5. Color or race..... Wb. 6.(a) Single, married, widowed, or divorced..... married

6.(b) Name of husband or wife..... Mary S. Ayres
6.(c) If alive, give age..... 79 years

7. Birth date of deceased (mo., day, yr.)..... Dec 26 1860

8. AGE: Years..... 85 Months..... Days..... If less than one day..... hrs. min.

9. Birthplace..... Rock Hall
(Town, county, and state)

10. Usual occupation..... retiree

11. Industry or business..... self

12. Name..... George Ayres

13. Birthplace..... Rock Hall, Md

14. Maiden name..... Sarah Leatherbury

15. Birthplace..... not known

16. Informant..... Wm. M. Ayres
Address..... Rock Hall Md.

17. BURIAL Date thereof..... May 8, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Wesley Chapel

Location..... Rock Hall Md.

18. Funeral director..... J. Willis Walls

Address..... Chesapeake, Md.

19. May 8 19 46 5. Edward Burgard
(Date read by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 5 19 46 at 345 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19 45 to May 5 19 46

and that I last saw him alive on May 4 19 46

Immediate cause of death..... old age, arteriosclerosis

myocardial infarction

Due to..... chronic endo, myocarditis

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

23. SIGNATURE..... Albert D. Burgard

Address..... Rock Hall, Md Date signed..... 7-7-46

RECEIVED
MAY 15 1946
RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

04918



Reg. Dist. No. 201

1. PLACE OF DEATH:

County Kent
 City or town Lynch md
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 16 years
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Kent
 City or town Lynch md
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Mrs Ida Beck

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female W Widow

6. (b) Name of husband or wife Wesford Copper

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Jan 29 1859

8. AGE: Years Months Days It less than one day
87 3 13 _____ hrs. _____ min.

9. Birthplace Kent Co
(Town, county, and state)10. Usual occupation Nurse11. Industry or business nurse12. Name Robert Beck13. Birthplace Horton md14. Maiden name Wesford Copper15. Birthplace Kent Co md.16. Informant John JewellAddress Lynch md17. Burial Date thereof May 15/1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Still Pond mdLocation Still Pond md18. Funeral director B R CrelwellAddress Still Pond md

19. May 15 46 J Melnick
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12 19 46 at 5:15 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

February 19 40 to May 3 19 46and that I last saw her alive on May 6 19 46

Immediate cause of death

Apoplexy

Due to

Apoplexy

Due to

Sepsis

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op. _____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury

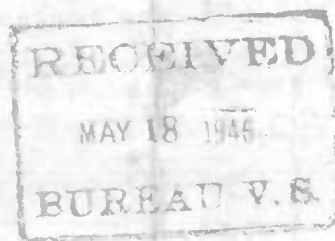
Injured at work?

23. SIGNATURE

Frank W Smith M. D. 8/13/46
 Address _____ Date signed _____

DURATION

5 years2 years4 mos



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 157-2

CERTIFICATE OF DEATH

★ 04219 200
Reg. Dist. No.

1. PLACE OF DEATH:

County Kent
City or town Millington (Kear)
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

3. (a) FULL NAME

George Gilbert Brown

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6 (b) Name of husband or wife

6 (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.)

April 27th 46

8. AGE:

Years

Months

Days

If less than one day

9

hrs.

min.

9. Birthplace

Kent Co. Maryland
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

William E. Brown

13. Birthplace

Maryland

14. Maiden name

Elsie E. Wall

15. Birthplace

Maryland

16. Informant

William E. Brown

Address

Millington Ar. Bural
April 7, 1946

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Crumpton

Location

Crumpton

18. Funeral director

E. L. Lane

Address

Church Hill

19.

(Date rec'd by registrar)

19 46

Edward L. Collins
deputy Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Kent
City or town Millington (Kear)
(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2 (a) IF VETERAN, NAME WAR

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5th 1946, at 2 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 27th 1946, to May 5th 1946, and that I last saw him alive on May 4th 1946.

Immediate cause of death Spontaneous Cause of Heart Failure

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings:

Df operations

Df autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of Injury _____ Injured at work? _____

23. SIGNATURE

G. P. Cofeland

M. D. or other

Address Millington Date signed May 6th 46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 5 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04920

Reg. Dist. No. 202

1. PLACE OF DEATH:

County Kent
 City or town Chestertown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Kent
 City or town Chestertown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 105 Railroad Ave
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Etta B. Chambers

3. (b) Social Security Number

4. Sex Female 5. Color or race Col 6.(a) Single, married, widowed, or divorced Widowed
 6.(b) Name of husband or wife Isaac Chambers
 7. Birth date of deceased (mo., day, yr.) Dec 15 1880 6.(c) If alive, give age _____ years
 8. AGE: Years 65 Months 5 Days 8 If less than one day _____ hrs. _____ min.

9. Birthplace Chestertown, Md
 (Town, county, and state)
 10. Usual occupation Housework
 11. Industry or business own house
 FATHER 12. Name George Brown
 13. Birthplace Shillpond, Md
 MOTHER 14. Maiden name Caroline Starling
 15. Birthplace Chestertown, Md

16. Informant Jalie M. Hynson
 Address 103 R.R. Ave Chestertown
 17. Burial Date thereof 5-26-1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Timber Neck Cemetery (Col)
 Location Chestertown Maryland
 18. Funeral director J. Willis Wells
 Address Chestertown Md

19. May 25 1946 Clara S. Barnes
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 23 1946 at 9:20 A M
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1946 to May 23 1946
 and that I last saw him alive on 5-22 1946

Immediate cause of death Pulmonary Tuberculosis
chronic Endo-myocarditis

Due to _____ DURATION _____
 Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of Injury _____ Injured at work? _____

23. SIGNATURE Albert H. Burgard M. D. or other
Rock Hall, Md Address _____ Date signed 5/23/46

RECEIVED

MAY 28 1946

BUREAU V B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

CERTIFICATE OF DEATH

04921

Reg. Dist. No. 201

1. PLACE OF DEATH:

County KentCity or town Chester town
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 day

Hospital, institution, or street address where death occurred:

Kent and Queen Anne's HospitalHow long in hospital or institution? 1 day

3. (a) FULL NAME

William Chambers

3. (b) Social Security Number

4. Sex

Male

5. Color or race

Black

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Bula chambers

7. Birth date of

deceased (mo., day, yr.) unknown 1878

8. AGE:

68 Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Kent Co
(Town, county, and state)

10. Usual occupation

Farmer labor

11. Industry or business

Army

FATHER

12. Name

Fortan Chambers

13. Birthplace

Kent, Co. Md.

MOTHER

14. Maiden name

unknown

15. Birthplace

Kent Co Md.

16. Informant

Joseph Murphy

Address

7816 Walnut St. Wilmington

17. Burial

(Burial, cremation, or memorial. Which?)

Date thereof

May 23/46
(month) (day) (year)

Cemetery or crematory

Coleman's rd.

Location

near Worton rd. Rural

18. Funeral director

B.R. Wellons

Address

Still Pond rd.

19. May 22

19. 46

(Date read by registrar)

J. McLoch

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Kent

City or town

C. J. Worton
(If outside city or town limits, write RURAL and give nearest town)

Street No.

Coleman's Corner
(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 19

19. 46

at 9:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 18

19. 46

to

May 19

19. 46

and that I last saw him alive on

May 19

19. 46

Immediate cause of death

Tuberculous peritonitis

DURATION

2 days

Due to

intestinal tuberculosis of

Due to

large and small bowel

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

intestinal tuberculosisPeritonitis generalizedDate of op. 5-19-46

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

A. C. WickW. C. W.

M. D. or other

Address

Chaptown, Md.Date signed 5-19-46

RECEIVED
JUN 4 1944
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 04922 202

1. PLACE OF DEATH:

County KentCity or town Charleston
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Sept. 1946

Hospital, institution, or street address where death occurred:

Kent-Delaware Area General HospitalHow long in hospital or institution? 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County KentCity or town Charleston
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2(a) If veteran, name war _____

3. (a) FULL NAME

Ida V. Crow

3. (b) Social Security Number

4. Sex Female5. Color or race White6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife _____

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) May 23, 18668. AGE: Years 79 Months 11 Days 21 It less than one day _____ hrs. _____ min.9. Birthplace Cecil County, Maryland
(Town, county, and state)10. Usual occupation Housework

11. Industry or business

12. Name William T. Crow13. Birthplace Cecil Co., Md.14. Maiden name Anna Maria Rankin15. Birthplace Delaware16. Informant Hospital RecordsAddress Charleston, Maryland17. Burial Date thereof May 16, 1946
(Burial, cremation, or removal. Where?) (month) (day) (year)Cemetery or crematory ShenandoahLocation near Kennedyville18. Funeral director Marion J. WilliamsAddress Charleston, Maryland19. May 15 1946 Clair L. Barnes
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13 1946, at 1:25 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1943 to May 13 1946 and that I last saw him alive on _____ 19____.

Immediate cause of death _____

DURATION

Cardiac Neoplasm 1943

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Lawrence Smith M. D. or otherAddress Charleston Date signed 7/2/46

DEPARTMENT OF JUSTICE

CERTIFICATE OF DEATH

RECEIVED
MAY 16 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04923

Reg. Diat. No. 202

1. PLACE OF DEATH:

County... Kent

City or town... Chestertown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? ... life

Hospital, institution, or street address where death occurred:

Kent and Queen Anne County Hospital

How long in hospital or institution? ...

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Md. County... Kent

City or town... Chestertown
(If outside city or town limits, write RURAL and give nearest town)

Street No... R.F.D.

(If rural, give LOCATION)

2.(a) If veteran, name war... no

3. (a) FULL NAME

Mary Emma Goodman

3. (b) Social Security Number

none

4. Sex

female

5. Color or race

whit

6.(a) Single, married, widowed, or divorced

widowed

6.(b) Name of husband or wife... J. Robert Goodman

6.(c) If alive, give age... years

7. Birth date of deceased (mo., day, yr.) Sept. 2, 1875

8. AGE: Years Months Days If less than one day

70

7

27

hrs. min.

9. Birthplace... KENT CO MARYLAND
(Town, county, and state)

10. Usual occupation... Housewife

11. Industry or business

12. Name... WM. F. WOOD MENDER

13. Birthplace... QUEEN ANNE CO. Md

14. Maiden name... SARA JANE HOLDEN

15. Birthplace... QUEEN ANNE Md

16. Informant... Hospital Records

Address... Chestertown, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof... May 9, 1946
(month) (day) (year)

Cemetery or crematory... Chester Cem.

Location... Chestertown, Md.

18. Funeral director... J. Willis Wells

Address... Chestertown, Md.

19. May 9, 1946 (Date filed by registrar)

Charles S. Barnes

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... May 6, 1946, at 2 P.M.

21. CERTIFY that death occurred on the date above stated; that I attended deceased from April 9, 1946, to May 6, 1946

and that I last saw him alive on May 6, 1946

Immediate cause of death... Myocarditis

Other conditions... Asymptomatic

Other conditions... Asymptomatic

Other conditions... Asymptomatic

Other conditions... Asymptomatic

Other conditions... Asymptomatic

Other conditions... Asymptomatic

Other conditions... Asymptomatic

Other conditions... Asymptomatic

Other conditions... Asymptomatic

Other conditions... Asymptomatic

Other conditions... Asymptomatic

Other conditions... Asymptomatic

Other conditions... Asymptomatic

Other conditions... Asymptomatic

Other conditions... Asymptomatic

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Other conditions... Asymptomatic

Other conditions... Asymptomatic

Other conditions... Asymptomatic

Other conditions... Asymptomatic

Other conditions... Asymptomatic

Other conditions... Asymptomatic

Other conditions... Asymptomatic

Other conditions... Asymptomatic

Other conditions... Asymptomatic

Other conditions... Asymptomatic

Other conditions... Asymptomatic

RECEIVED
MAY 11 1946
BUREAU

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 4924 200

1. PLACE OF DEATH:

County Kent County
 City or town Millington Md.
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

non

How long in hospital or institution?

non

3. (a) FULL NAME

Maggie Groves

3. (b) Social Security Number

4. Sex

Female

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Willie Groves

Dec 9

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

Dec 9, 1880

8. AGE:

Years

Months

Days

If less than one day

66

hrs.

min.

9. Birthplace

Md.
(Town, county, and state)

10. Usual occupation

House Work

11. Industry or business

12. Name James Jefferson13. Birthplace Md.

MOTHER

14. Maiden name

Don't know

15. Birthplace

Don't know

16. Informant

Moyle Haller

Address

Millington Md.

17. (Burial, cremation, or removal. Which?)

Burial

Date thereof

May 18, 1946
(month) (day) (year)

Cemetery or crematory

Relay mess Cemetery

Location

Near Millington

18. Funeral director

Calvin Blair

Address

112 So Green St Done Or.

19. (Date rec'd by registrar)

May 13, 1946Edward Holloway

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

M D.

County

Kent County

City or town

Millington
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

non

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 13, 1946 at 4 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 1, 1946 to May 13, 1946and that I last saw him alive on May 10, 1946

Immediate cause of death

Anoxia of Heart

DURATION

Long

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Wm H Biss

M. D. or other

Address

Millington Md Date signed 5/12/46

RECEIVED
JUN 5 1946
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 92-2

CERTIFICATE OF DEATH

Reg. Dist. No. 04925 201

1. PLACE OF DEATH:

County StuartCity or town Betterton Md
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3.5 yearsHospital, institution, or street address where death occurred: _____How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County KentCity or town Betterton Md
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)2(a) If veteran, name war _____

3. (a) FULL NAME

George Washington Jess

3. (b) Social Security Number

4. Sex Male 5. Color or race W 6. (a) Single, married, widowed, or divorced Single6. (b) Name of husband or wife _____7. Birth date of deceased (mo., day, yr.) Feb 22 1872 6. (c) If alive, give age _____ years8. AGE: Years 74 Months 2 Days 13 If less than one day _____ hrs. _____ min.9. Birthplace New Jersey
(Town, county, and state)10. Usual occupation Fishing Mail Carrier

11. Industry or business

12. Name Charles F Jess13. Birthplace Salisbury N.J.14. Maiden name unmarried15. Birthplace New Jersey16. Informant Mrs. TullAddress Betterton Md17. Burial Date thereof May 16 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Still Pond MdLocation Still Pond Md18. Funeral director Still Pond MdAddress Still Pond Md19. May 15 1946 J McLean
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13 1946, at _____ M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4 or 5 years 1941 to 5/13/46 1946and that I last saw him alive on May 13 1946Immediate cause of death Coronary thrombosis DURATION _____Due to Vascular insufficiencyDue to _____Other conditions Pneumonia 3 or 4 yrs ago

(Include pregnancy within 3 months of death)

Major findings of operations _____Date of op. _____Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____Where did injury occur? _____ (City or town) (County) (State)Injured at home, farm, industry, public place (where?) _____Means of injury _____ Injured at work? _____23. SIGNATURE James E Dedman M.D. M. D. or other _____Address Box 19 Betterton Md Date signed 5/14/46

RECEIVED

MAY 18 1948

BUREAU V.B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83rd

CERTIFICATE OF DEATH

14926

Reg. Dist. No. 200

1. PLACE OF DEATH:

County Kent

City or town Rural Chesterville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For new-born infants give residence of mother)

State MD County Kent

City or town Rural Chesterville
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Cora S. Johnson

3. (b) Social Security Number

none

4. Sex

Female

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

James Johnson

6. (c) If alive, give age _____ years

7. Birth date of

deceased (mo., day, yr.) March 29 1883

8. AGE:

63

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

MD
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name

Samuel Wilson

13. Birthplace

MD

MOTHER

14. Maiden name

Maggie Turner

15. Birthplace

MD

16. Informant

James Johnson

Address

Rural Chesterville MD

17. Burial

(Burial, cremation, or removal, etc.)

Date thereof

June 2 1946
(month) (day) (year)

Cemetery or crematory

Chesterville

Location

Rural Chesterville MD

18. Funeral director

Edward Fellows

Address

Millington MD

19. June 1

(Date rec'd by registrar)

1946

Edward Fellows
Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 28 1946 at 1 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 28 1946 to May 28 1946

and that I last saw him alive on May 28 1946

Immediate cause of death

Hemiplegia

DURATION

6 P.m.

Due to

Cerebral Sclerosis

2 years

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury

Injured at work?

23. SIGNATURE

Edward Fellows

M. D. or other

Address Millington MD Date signed 5/11/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 20 1944
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 742

14927

CERTIFICATE OF DEATH

Reg. Dist. No. 204

1. PLACE OF DEATH:
County.....
City or town.....
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?.....
Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME.....

4. Sex.....

5. Color or race.....

6. (a) Single, married, widowed, or divorced.....

8. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.).....

6. (c) If alive, give age..... years

8. AGE: Years..... Months..... Days..... If less than one day..... hrs. min.

9. Birthplace.....

10. Usual occupation.....

11. Industry or business.....

12. Name.....

13. Birthplace.....

14. Maiden name.....

15. Birthplace.....

18. Informant.....

Address.....

17. Burial, cremation, or removal (Which?)..... Date thereof..... (month) (day) (year)

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address.....

19. May 12 1946..... Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State..... County.....
City or town.....
(If outside city or town limits, write RURAL and give nearest town)

Street No.....
(If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number.....

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 1946

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... to.....

and that I last saw him/her live on.....

Immediate cause of death.....

Other conditions.....

Other conditions.....

Other conditions.....

Other conditions.....

Other conditions.....

Other conditions.....

Other conditions.....

Other conditions.....

Other conditions.....

Other conditions.....

Other conditions.....

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Other conditions.....

Other conditions.....

Other conditions.....

Other conditions.....

Other conditions.....

RECEIVED

MAY 20 1946

BUREAU U. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 160-2

CERTIFICATE OF DEATH

14928

Reg. Dist. No. 2021

1. PLACE OF DEATH:

County Kent
 City or town Chestertown Md.
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Kent + Queen Anne's Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Queen Anne
 City or town Centerville
 (If outside city or town limits, write RURAL and give nearest town)

Street No.
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Baby Boy Moore

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

MW-

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day
X X X hrs. 30 min.

9. Birthplace Chestertown, Kent Co., Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name James William Moore13. Birthplace Centerville, Md.14. Maiden name Catherine Benton15. Birthplace Georgetown, Md.16. Informant Mr. James Lee MooreAddress Centerville, Md.17. (Burial, cremation, or removal, Which?) Date thereof May 17-46
(month) (day) (year)Cemetery or crematory Steenerville Md.Location Steenerville Md.18. Funeral director Benton BrosAddress Centerville, Md.19. May 16 19 46 Clara S. Barnes
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16 19 46 at 12:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 15 19 46 to May 16 19 46
 and that I last saw him alive on May 15 19 46

Immediate cause of death

Birth trauma

DURATION

30 min

Due to

ROP (Right of Preterm)

Due to

at Steenerville

Other conditions

UTI

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Centerville Date signed 5-16-46

RECEIVED
MAY 18 1946
BUREAU V.S.